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Health Policy in Canada

Joan Vance
Political and Social Affairs Division

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HEALTH POLICY IN CANADA

ISSUE DEFINITION

Responsibility for all matters related to the health status of Canadians is shared between the federal and provincial governments. Health policy can be divided into two categories: (1) sickness care and preventive health and (2) health promotion. Most improvements in the health status of Canadians in the past have been attributed to measures in the first category. Certain demographic trends, however, suggest that hope for further improvements in the health of Canadians may lie in the second.

BACKGROUND AND ANALYSIS

A. Government Responsibility for Health

At Confederation, government involvement in health was minimal. People relied on their own resources and those of the family; hospitals were administered and financed by private charities and religious organizations. The only specific references to health matters in the Constitution Act, 1867 allocated jurisdiction over marine hospitals and quarantine to the federal government and jurisdiction over hospitals, asylums, charities and charitable institutions to the provinces. Since the provinces were assigned all matters of a local or private nature, as governments became increasingly more involved in the health field, the provision of health services was acknowledged as primarily a provincial responsibility. Federal government involvement came about largely as a result of the spending powers given to that level of government in the Constitution.

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The principal federal department for health matters is Health and Welfare Canada, which pursues the objective of maintaining and improving the health of Canadians in conjunction with other federal agencies and with provincial and local governments. The federal government is responsible for payments to provincial health insurance programs covering hospital, diagnostic, medical and extended health care services, as provided for in legislation. This involves federal monitoring of the provincial compliance with basic program conditions on which federal payments depend. The federal government also carries out a wide range of activities intended to protect Canadians from hazards to health. These activities include protection of food safety and nutritional quality, the safety and effectiveness of drugs and medical services and reduction and monitoring of environmental health hazards such as dangerous chemicals, radioactivity and disease.

In the area of health promotion, the federal government works closely with the provincial governments and non-government organizations to develop and deliver health education and information in areas such as nutrition, drug and alcohol use, smoking, and family, child and individual health care. In addition, the federal government has special responsibilities for the health of aboriginal people, residents of Yukon and the Northwest Territories, immigrants and public servants at home and abroad. It must also support scientific research and related activities and provide for the training and maintenance of health research personnel. Finally, physical fitness is promoted, encouraged and developed through the Fitness and Amateur Sport Program of Health and Welfare Canada.

The formal structure established to facilitate federal-provincial cooperation in the health field consists of a Conference of Ministers of Health and a Conference of Deputy Ministers of Health who meet periodically. Additional bodies which deal with particular health issues are federal-provincial advisory committees on Institutional and Medical Services, Community Health, Health Human Resources, Mental Health, International Health Affairs and Environmental and Occupational Health.

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B. Financing the Canadian Health System

In addition to the power to legislate in certain areas, the Constitution Act, 1867 gave the federal government the power to spend moneys from the consolidated revenue fund on any activity, providing that the legislation authorizing the expenditure did not fall within provincial powers. This spending power enabled the federal government to make payments to the provinces and persons in the health field, for example, to hospital and medical care insurance programs, health grant programs, health resources and fitness and amateur sport. It also enabled the federal government to provide consultation and information services and to undertake research.

Nationwide health insurance is provided in Canada through interlocking provincial/territorial hospital and medical care insurance plans. To qualify for federal financial support these plans must meet the following minimum criteria: (1) universal population coverage; (2) comprehensiveness of coverage; (3) reasonable access to service; (4) portability of benefits; and (5) administration by a public agency on a non-profit basis. These criteria are intended to ensure that all Canadian residents have access to pre-paid hospital and medical care.

This national health insurance system was achieved in two steps: the Hospital Insurance and Diagnostic Services Act, 1957 and the Medical Care Act, 1966. Federal financing in relation to both Acts was extended to provincial plans through a 50-50 cost-sharing plan, which presented problems for both federal and provincial governments. The federal government was concerned about the open-ended nature of this health cost-sharing agreement and the provinces complained about its inflexibility in relation to the allocation of resources. A new block-funding program was introduced with the passage of the Federal-Provincial Fiscal Arrangements and Established Programs Financing Act in 1977. In 1984, the provisions of the two previous insurance acts were consolidated in the Canada Health Act reaffirming the program conditions and providing financial penalties for provinces permitting extra-billing and hospital user fees, practices which, from the federal point of view, violated

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minimum standards required for federal financial support. After significant federal-provincial conflict on these issues, all provinces complied with the Canada Health Act by the 1 April 1987 deadline.*

In 1985, the overall cost of health in Canada, including expenditures by the private sector and all levels of government, was 18 times that in 1960. **Health care now accounts for a large portion of provincial government budgets; e.g., approximately one quarter in New Brunswick and one third in British Columbia and Ontario. As much as 85% of this health expenditure is for doctors and hospitals and they are being pressured by governments to help contain health care costs. At the same time, governments are emphasizing health promotion and preventive measures as the ultimate solution to the rising costs. These measures not only reduce disease and disability but are also less expensive to provide than sickness care.**

C. Health Policy

As previously described, health policies fall generally into two categories: (1) sickness care and preventive health and (2) health promotion.

1. Sickness Care and Preventive Health

Traditionally, the health care system has involved only medical and other health care professionals and has focused on treatment and prevention of illness and premature death. The burden of ill-health has been enormously relieved since Confederation. Original improvements came with socio-economic developments and public health measures associated with the development of medical science. The passage of the Food and Drugs Act in 1920, for example, led to the protection of the food and drug supply. Six other pieces of legislation, including the Meat Inspection Act, the Fish Inspection Act and the Consumer Packaging and Labelling Act, were also important legislative tools in maintaining and improving the

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* For a more detailed discussion of these fiscal arrangements and associated problems related to criteria and conditions of payment for federal funding to provincial insurance plans see Medicare in Canada, Current Issue Review 79-24E, Research Branch, Library of Parliament.

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nutritional value of food. These serve as examples of the numerous cases where health policy requires cooperation among several other government departments, e.g., Agriculture Canada, Fisheries and Oceans and Consumer and Corporate Affairs. There were decreases in morbidity and mortality rates and, after the middle of this century, major changes in disease patterns; for example, many once prevalent infectious diseases, such as smallpox and diphtheria, were virtually eliminated. Gradually, nationwide health insurance, which would provide greater access to better services for the population in general, began to be considered as the best health policy.

Proposals for a national health insurance plan comprehending both hospital and medical care was part of the Green Book Proposals for postwar reconstruction in 1945. While these proposals did not become a reality at that time, national health insurance did become a matter of public concern and debate. Saskatchewan started its hospital insurance plan in 1947, well before federal assistance was available, and the Hospital Insurance and Diagnostic Services Act brought a national program of hospital insurance in 1957. The Royal Commission on Health Services (the Hall Commission) reported in 1964 that "the fruits of health sciences" were still not accessible to all Canadians and recommended a universal health services program for all Canadians as the "most effective use of the nation's health resources to attain the highest possible levels of physical and mental well-being."* In 1966, the Medical Care Insurance Act provided for public medical insurance.

Financing the increasingly high costs of health insurance was the focus of much federal-provincial conflict which resulted in two major changes to the original program. The Federal-Provincial Fiscal Arrangements and Established Programs Financing Act passed in 1977 shifted program financing from the original 50-50 federal-provincial cost-sharing arrangements to block funding. In this arrangement federal payments were calculated independently of provincial expenditures and required the provinces to spend the federal contribution in the health field but not

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* Royal Commission on Health Services, Report, Queen's Printer, Ottawa, 1964, p. 11.

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necessarily to make matching expenditures. The 1984 Canada Health Act was the second major change. This Act consolidated the two previous acts and made the abolition of extra-billing and hospital user fees a condition of federal funding.

Since the advent of medicare the fee-for-service system and discretionary decision-making powers of physicians have come under increasing pressure. With the end of extra-billing, individual physicians ceded to provincial governments discretion over the price of their services. Some controversy continued around administrative charges, the definition of insured services and overall increases in the fee schedule. Some research suggests that, faced with fee constraints, physicians may increase the number of patient visits and the number of services provided. According to this view, there must ultimately be controls on "utilization"; i.e. how much doctors can bill, if costs are to be contained. An alternative strategy, now being tried by some provincial governments, particularly Quebec and Ontario, is to establish group practices and clinics funded on a per capita or global budget basis (similar to Health Maintenance Organizations in the United States) under contract to a government insurance plan. This approach promises to limit further the decision-making authority of physicians within the health care delivery system.

Some experts still argue that the Canada Health Act may have to be amended to allow charging patients for "non-essential" medical and hospital services and thus keep down the demand for such services, which they see as fuelling rising health care costs. Others reject this solution, fearing that the definition of "non-essential" will be so broad and arbitrary as to infringe on the principle of universal access to health care. Recent attempts by the Alberta government to de-insure tubal ligations and vasectomies, by the British Columbia government to refuse medicare coverage for abortions and by the New Brunswick government to charge cancer patients a fee for out-patient beds in hospitals were all evantually abandoned in the face of public protest or, as in the British Columbia case, were thwarted by the courts.

Nurses and other health care workers have also resisted some strategies to reduce health costs which they view as contrary to their

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interests. The United Nurses of Alberta, for example, made clear recently that a proposal by a provincial government commission for private nursing companies to contract services to hospitals and nursing homes on a fixed-fee basis was not palatable to them.

The controversy concerning the funding of the "health care system" continues. Meanwhile, provincial governments must deliver the sickness care services which the public has come to expect and on which additional demands can be expected to be made as a result of such factors as the increasing number of elderly people, the AIDS epidemic and the striking down by the Supreme Court of Canada of the abortion law. The situation faced by the provinces is further complicated by the high costs of expanding medical technology, an impending surplus of physicians, fee demands, wage and salary negotiations with professionals and workers in the field and a lack of incentives for hospital efficiency. **Many provinces, including Quebec, Ontario, Alberta, Nova Scotia and Saskatchewan, have recently undertaken major studies of their health care systems and the provincial premiers announced, in August 1988, that they will study the funding of health care in the future in three national symposiums next year.** There is concern generally about the cost of continuing to provide health services based on the traditional medical model.

Many health care professionals argue that the health of Canadians is being seriously jeopardized by underfunding of the sickness care delivery system. On the other hand, the federal government and other health care specialists argue that putting more money into the existing system will not necessarily improve the present health status of the population. They claim that improved health and controlled costs, will be best achieved through an emphasis on health promotion. **Dr. Robin Walker, Vice-President of the Canadian Council on Children and Youth, told the Standing Committee on Health and Welfare, on 2 May 1988, that the savings from reducing the low birth weight rate, even by 1%, would be billions of dollars a year. The cost of caring for each of Canada's surviving underweight babies is about $100,000 annually. The incidence of low-birth weight babies is highest in populations characterized by young mothers with poor overall health care and lifestyles. Health promotion and preventive**

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measures can improve this situation and can modify lifestyle characteristics related to cardiovascular disease, which also exerts extreme pressure on health care funds.

2. Health Promotion

In the early 1970s and 1980s, demographic and disease trends indicated that hope for further improvements in the health status of Canadians lay in the area of health promotion. Trends such as the aging of the population and the high incidence of certain diseases and disabling conditions related to lifestyle, e.g., cardiovascular disease, cancer, accidents and mental illness, led to a new emphasis on the reduction of risk to health, early detection of health problems and improvements in rehabilitation and coping strategies. In 1974, A New Perspective on the Health of Canadians: A Working Document, published by Marc Lalonde, Minister of National Health and Welfare, spelled out guidelines for a health planning approach.

Health promotion, though similar to the preventive measures associated with the "old public health" concept is a "holistic" approach that focuses on the total population in the physical and social environment. It is therefore related to matters such as environmental pollution, family violence, highway accidents, stress and workplace hazards which are outside the realm of health policy. This "new public health" is also holistic in the sense that it focuses on whole individuals in their total day-to-day environment. Health is considered as a state for which people strive and not as merely the outcome of curing, treating or preventing illness and injury. Health promotion also entails the coordination of health policy with other policies. Within the health field itself, it would imply the sharing of responsibility and resources by governments and health professionals with individuals planning their personal health strategies, and community and other support groups, not previously regarded as part of the health care team.

In 1977, Canada endorsed the health planning program and policy initiative of the World Health Organization (WHO), Health For All by the Year 2000. Influenced by the Lalonde Report, Health and Welfare Canada and Statistics Canada conducted a health survey in 1978-79 which, unlike

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previous health surveys, was based on a health promotion approach. This Canada Health Survey collected information not only on disease and disability but also on demographic correlates of lifestyle and preventive health practices. In 1985, the National Health Promotion Survey updated the information in the previous survey and provided comprehensive information on people's knowledge of and attitudes toward their behaviour. A key finding of this second survey was that knowledge about health matters and belief in their importance do not necessarily lead to better health or changed behaviour. In other words, providing information alone is not an adequate preventive health strategy. In November 1986, Mr. Epp, Minister of National Health and Welfare, presented a plan for health promotion in a paper at the International Conference on Health Promotion in Ottawa. In this paper, Achieving Health For All: A Framework For Health Promotion, three challenges to the Canadian health system identified in the Health Promotion Survey were discussed:

(1) the low health status of low-income groups, children, women, the elderly, natives and immigrants;

(2) the need to prevent harmful lifestyles and behaviours such as drinking, smoking and consumption of high fat diets which contribute to high incidence diseases such as lung cancer, liver disease, cardiovascular disease and accidents;

(3) the need for individuals, families and communities to develop coping mechanisms to deal with chronic health problems associated with aging, mental illness and other socially and physically disabling conditions.

The best mechanisms for addressing these challenges, the paper suggests, are: self-care, where people take an interest in and make decisions about their own health; mutual aid, where people help each other to cope; and healthy environments, conditions and surroundings conducive to health. Three strategies suggested in the paper for establishing these mechanisms were: (1) fostering public participation; (2) strengthening community health services; and (3) coordinating public health policy.

There have been some accomplishments in health promotion: greater public awareness of the benefits of fitness and proper nutrition; government anti-smoking campaigns; legislation making the use of seat belts

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compulsory; and allocation by the the federal government of $30 million annually to improve the quality of life of the elderly through self-care projects and education. Health promotion policy is only just beginning to touch the sickness care system itself. Alternatives to long-term hospitalization of the elderly and rehabilitative services for them after release from hospital are being developed and inexpensive preventive and self-help programs are being established to make more rational use of health personnel and resources.

Increasingly greater numbers of health professionals and experts agree that there are long-term savings and benefits in pursuing the goals of health promotion and disease prevention rather than treating sickness after it occurs. Recent health promotion initiatives include a federal program to fight alcohol and drug abuse in elementary and high schools. The federal and Manitoba governments announced a new research centre in Winnipeg to design and market special health care products and services which will help elderly people and the disabled live safely in their own homes. Some health observers suggest that reorienting the health system will probably not come about until it is demanded by a public which sees such reorientation as superior to the scientific and technological approach of the existing system.

Some health experts see employment trends as very relevant to public health. The trend away from secure full-time jobs toward part-time minimum wage positions, they fear, will contribute to poverty and poorer health in Canada. People living in poverty tend to have poor nutrition and a sense of hopelessness that may lead them to have less caution in adopting a lifestyle which might contribute to potential health problems. Such employment trends could reverse the gains made to date in promoting healthy lifestyles.

The health status of native people and the level and appropriateness of native health services are demanding more attention. A federal inquiry into native health services began in September following a hunger strike by four Cree protesting about the services at Sioux Lookout Zone hospital in Ontario.

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PARLIAMENTARY ACTION

The Constitution Act, 1867 made few direct references to government responsibility for health because governments had only minimal involvement in the field at that time.

The Hospital Insurance and Diagnostic Services Act, 1957 introduced a national hospital insurance program.

The Medical Care Act, 1966 introduced a national medical insurance program.

The Federal-Provincial Fiscal Arrangements and Established Programs Financing Act, 1977 changed the cost-shared funding arrangements for health insurance between the federal and provincial governments to block funding.

The Canada Health Act, 1984 (Bill C-3) consolidated the provisions of the two previous insurance acts and reaffirmed and strengthened the federal government's commitment to universal prepaid national health insurance.

CHRONOLOGY

1867 - The only references to health in the Constitution Act allocated responsibility for marine hospitals and quarantine to the federal government and jurisdiction over hospitals, asylums, charities and charitable institutions to the provinces.

1957 - The Green Book Proposals on postwar-reconstruction contained recommendations for a national health insurance program.

1957 - The Hospital Insurance and Diagnostic Services Act introduced national hospital insurance.

1964 - The report of the Royal Commission on Health Services (the Hall Commission) advocated a national medical insurance program.

1966 - The Medical Care Act provided for a national medical insurance program.

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1974 - Marc Lalonde, Minister of National Health and Welfare, published A New Perspective on the Health of Canadians: A Working Document which offered a new health planning approach.

1977 - The Federal-Provincial Fiscal Arrangements and Established Programs Financing Act made it a condition of federal payments that a province must show that its plan satisfied the federal medicare criteria.

1980 - The Health Services Review '79 reported that extra-billing by physicians and hospital user fees were endangering the principle of reasonable access to health-care.

1981 - The Health of Canadians: Report of the Canada Health Survey was released offering information not just on disease and disability but also on lifestyle, environment and socio-economic factors related to health.

1984 - The Canada Health Act consolidated the two previous Acts and reaffirmed and strengthened the federal commitment to universal prepaid public health insurance.

November 1986 - The Federal Minister of National Health and Welfare, J. Epp published a discussion paper, Achieving Health For All: A Framework for Health Promotion. The paper, presented at the International Conference on Health Promotion, outlined a health promotion policy for Canada.

April 1987 - The main findings of the 1985 National Health Promotion Survey were published in the Active Health Report. For the first time, information on knowledge about and attitudes toward certain lifestyle behaviours and preventive health practices were gathered as a basis for an informed health promotion strategy.

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